

Evidence and Ethics

THE ILLUSION OF SHARED ETHICS

The illusion of shared meaning naturally gives rise to a further worrying mirage – *the illusion of shared ethics*. At the heart of any health promotion project there will be very many ethical matters which ought to be aired, explained and discussed by all those affected (promoters and recipients alike).²⁵ Yet despite this there is, amongst the majority of health promoters, strikingly little serious debate about the ethics of what they are doing (most of the discussions that do exist are not particularly penetrating).^{26,27,28} Ethics is rarely thought to be an issue in standard health promotion work (Tones and Tilford,¹⁰ for instance, fail even to list ethics in their subject index) even though it ought to be the first, last and integral concern of any project. The reason for such a gross oversight is most probably this: unless you possess a substantial understanding of the reasons why you value health promotion it is extremely difficult to offer an ethical justification for your practice, and harder still to admit that alternative ethical positions are worthy of consideration.

In order to appreciate the extent to which ethics pervades health promotion – and therefore to see the full size of the discipline's theoretical crisis – it is necessary to be aware of the difference between facts and values: an extremely important philosophical distinction which, remarkably, remains almost entirely invisible in health promotion.

FACTS AND VALUES, EVIDENCE AND ETHICS – AN INITIAL EXAMPLE

If health promotion is associated with any one thing in the public eye, it is the campaign against smoking. Almost everyone, it seems, accepts that *as a matter of fact* smoking is bad for health, that it should be discouraged or even banned in some situations and that it is unquestionably ethical that health promoters do what they can to reduce smoking levels. But it is not, as the following illustration demonstrates, beyond doubt.

FOUR MORALLY CONTROVERSIAL HEALTH PROMOTION PLANS

Here is **Plan A**:

Health Promotion Plan A

HEALTH PROMOTERS SHOULD ENCOURAGE PEOPLE TO SMOKE

Because

- Smoking helps people cope with life
- Promoting smoking will help the tobacco industry employ more people (it is well known that unemployment is a cause of ill-health)
- Smoking raises taxes which governments can elect to spend on health services
- Smoking reduces the level of chronic sickness in the elderly population because smokers tend to die sooner than non-smokers. Promoting smoking will lower the cost to the state of geriatric care
- Young people think smoking is cool – it makes them feel they belong, and a sense of belonging is very important for health
- Smoking is enjoyable – most smokers get pleasure out of smoking

HEALTH PROMOTERS SHOULD ENCOURAGE PEOPLE TO SMOKE BY MEANS OF ONE OR MORE OF THE FOLLOWING METHODS

- *Campaigning for unrestricted advertising* – in a capitalist country it ought to be legal to advertise any product that it is legal to sell
- *Comprehensive advice on how to get the very most enjoyment from cigarette smoking* – what to smoke, what strength cigarette is best in which circumstances, when to use a filter and when not, how to roll your own, what the optimum frequency should be (this advice should be based on detailed scientific research undertaken by health promoters)
- *Advertising widely the many mental and social benefits that smoking offers*

There are a handful of organisations²⁹ which argue that individuals have a right to smoke if that is what they choose to do, just as they have a right to engage in other behaviours which carry personal risks. But not even these groups dare claim that smoking is actually *good* for health (it is highly unlikely that any would be so bold as to put forward **Plan A** as a *health promotion* strategy).

Nowadays variations on **Plan B** abound. Yet even though it may look as if anti-smoking policies are factually desirable, closer study quickly shows this is not so. **Plan B** is not based only on matters of fact, nor is it obviously the right thing to do. I might think it is persuasive. So might you. But it nevertheless remains partly a point of view. **Plan B** is a combination of evidence *and* supposition, and is therefore open to challenge – and not only from those opposed to no-smoking health promotion. **Plan B** ought to be continually debated *within* a reflective health promotion movement, since it is not *obviously* the healthiest strategy.

Here is **Plan B**:

Health Promotion Plan B

HEALTH PROMOTERS SHOULD TRY TO STOP PEOPLE SMOKING

Because

- Smoking causes sickness and shortens lives
- Smoking makes people unfit
- The medical treatment of smoking-related disease is expensive. Where such disease is treated by publicly funded medical services smoking incurs financial cost to the state
- Smoking leads to absenteeism and loss of productivity, and so incurs further cost to the state
- Smoking damages non-smokers, physically (through passive smoking) and economically (because of its cost to the state – a cost which is ultimately borne by the individual taxpayer)
- Smoking is unaesthetic (it stains) and unhygienic (it smells)

HEALTH PROMOTERS SHOULD TRY TO STOP PEOPLE SMOKING BY MEANS OF ONE OR MORE OF THE FOLLOWING METHODS

- *Education* – smokers should be presented with comprehensive evidence about the damage they do to themselves and others, and enabled to make fully informed choices
- *Training* – stop-smoking techniques should be freely and liberally available wherever people smoke. People should be given every opportunity to change their behaviours
- *Indoctrination* – anti-smoking propaganda should be widely distributed to counteract the marketing campaigns of the tobacco companies. It should be made plain that tobacco-related disease is to be feared (scary real life images should be used), and the huge profits that tobacco companies make as a result of their trade should be given maximum publicity – as black a picture as possible should be painted about the undesirable effects of smoking and the immorality of the tobacco industry
- *Legislation* – tobacco advertising should be banned, tobacco products should be taxed at a very high rate, smoking in public should be forbidden, smokers should be forced to bear the cost of all medical treatments made necessary by their smoking, smokers should be separated from non-smokers wherever possible
- *Prohibition* – smoking should be outlawed altogether

Both **Plans A and B** *originate* in alternative interpretations of the merits of smoking – neither plan is a neutral response to evidence, rather each is constructed according to this general formula:

Various pieces of evidence+Various sorts of opinion=A health promotion plan

Therefore *both* **Plan A** and **Plan B** are morally controversial. Any plan based on the above formula must be. No doubt **Plan A** will appear manifestly problematic – perhaps even shocking to some people – while initially only parts (if anything) of **Plan B** will seem to require ethical justification. But even though the plans may seem to be in completely different moral dimensions, appearances can be highly deceptive.

Because late twentieth century Westerners have become so accustomed to the unremitting association of the words 'smoking' and 'bad for your health' this may not be easy to digest. If so, the following illustration should dispel any residual illusion. Let's get it straight: **Plan B** is *just as arguable* as **Plan A**.

ANTI-RUGBY HEALTH PROMOTION

New Zealanders are passionate about Rugby Union. In a nation of around 3.5 million people there are approximately 300 000 regular rugby players.³⁰ Looked at from one point of view so much regular exercise undertaken on such a large scale seems to be just what the (health promotion) doctor ordered. However rugby is a dangerous game, injuries are common, and cost the New Zealand nation approaching NZ\$30 million each year – or the equivalent of about NZ\$1 million every playing Saturday (this money is paid through a 'no-fault' national injury and accident compensation scheme, administered by the Accident Compensation Corporation, and known as 'the ACC').³¹

There is greater risk of injury the higher the grade, but across all levels 13% of injuries result from foul play, 42% of players start each season with either a current injury and/or a chronic injury, and countless players place themselves at risk of various harms not during the match itself, but because (in keeping with hallowed tradition) they drink so much alcohol afterwards.

Now suppose that someone in government with responsibility for health promotion takes a hard look at these statistics and decides that rugby is an *unhealthy* activity. Suppose that this member of government believes it would be far better for the health of all New Zealanders if those who are presently addicted to playing rugby could be persuaded to stop. And suppose further that this government health promoter were to want to inaugurate a major campaign against rugby playing. Suppose she wanted to initiate **Plan C** (opposite):

Rugby is New Zealand's most important national institution. New Zealand's rugby players know the risks, they know the pleasures, and they are prepared to take their chances. It is, therefore, safe to say that the great majority of New Zealanders would not approve of **Plan C**, though its reasoning would be influential in some quarters, and a minority of the population would welcome it.

If **Plan C** were to be implemented (Kiwis readers: please try your best to suspend belief at this point) the value tensions and moral questions would be plain to see. It would be obvious that **Plan C** is *not purely factual*. Alternative evidence would be advanced in favour of rugby in response to the health promotion initiative. The plan would be attacked for exaggerating the risks and underplaying the benefits, there would be complaints about the insensitivity of the hard-hitting advertisements and protests that – because of raised anxiety – some rugby players could no longer take the same pleasure out of their game. No doubt there would be talk of rights, of the importance of people being free to choose, of the dangers of 'healthism' – it is easy to imagine the outcry. Yet this hypothetical proposal is very close to the reality of current anti-smoking health promotion and indeed virtually parallels the apparently unobjectionable **Plan B**.

Health Promotion Plan C

HEALTH PROMOTERS SHOULD TRY TO STOP PEOPLE PLAYING RUGBY

Because

- Rugby causes serious injury and shortens lives
- Rugby makes people unfit
- The medical treatment of rugby-related injury incurs considerable cost to the state
- Rugby leads to absenteeism and loss of productivity, and so incurs further cost to the state
- Rugby damages non-rugby players economically
- Rugby is unaesthetic, it promotes aggression, venerates brawn over brain, and presents a negative image of New Zealand to the world's more cerebral societies

HEALTH PROMOTERS SHOULD TRY TO STOP PEOPLE PLAYING RUGBY BY MEANS OF ONE OR MORE OF THE FOLLOWING METHODS

- *Education* – rugby players should be presented with evidence of the damage they do to themselves and others, should be shown alternative leisure activities, and enabled to make fully informed choices about their behaviours free from social pressures
- *Indoctrination* – anti-rugby propaganda should be widely distributed to counteract the marketing campaigns of the sportswear companies and brewers (who currently promote rugby very aggressively in New Zealand), glossy 'Stop Rugby' brochures should be sent to all New Zealanders, there should be a 'National No-Rugby Day' each year on a Saturday in July (mid-winter in New Zealand), and terrifying advertisements showing ex-rugby players paralysed as a result of neck injury should be repeatedly aired on TV
- *Legislation* – there should be a ban on the advertising of rugby games, admission to rugby matches should be highly taxed, and so on

EXERCISE THREE

EVIDENCE OR OPINION?

Take any of the **Plans A, B and C** and, if possible, distinguish:

1. Indisputable evidence
2. Disputable evidence
3. Statements of opinion

Then:

4. Identify those statements which most obviously have moral content
5. From this set extract two statements – one with which you most agree, the other with which you most disagree
6. Offer the strongest possible justification for your selection

Then:

7. Argue against your preferred statement
8. Argue in support of your least preferred statement
9. Finally, argue in favour of your most preferred statement

SMOKING TRUTHS?

Now consider one real example of anti-smoking health promotion. Here is a typical UK Health Education Authority (HEA) claim.³² For the sake of balance let's call this (part of) **Plan D**:

(Part of) Health Promotion Plan D

Smoking

Giving up smoking is the most important step people can take to improve their health . . .

Smoking Facts

A smoker runs two or three times the risk of having a heart attack as a non-smoker . . .

Smoking can lead to bad breath, staining and yellowing of teeth, shortness of breath, and addiction to nicotine . . .

Smoking is anti-social. As well as causing annoyance by making hair and clothes smell unpleasant, exposure to other people's smoke can cause eyes to hurt, headaches, coughs, sore throat, dizziness and nausea.

DIFFERENT TYPES OF FACT

Each of the statements in **Plan D** is presented as an uncomplicated and unarguable fact: the only problem being to convince those who do not know these facts, or who are too addicted, or who have too little will-power, to quit. Some of the statements are certainly factual: smoking can stain teeth, exposure to smoke can cause coughs and – given that certain additional conditions apply – a smoker does run two or three times the risk of having a heart attack as a non-smoker. However, to get a more complete picture of the smoking facts it is essential to be aware that there are different types of fact, and that the statements announced as **Plan D** actually make different levels of claim.

Consider, for instance, the statement 'smoking can stain teeth'. This is a straightforward assertion of a cumulative tendency of one action to cause one effect; it is testable, and it is certainly true (it is also true that 'smoker's toothpaste' will remove most stains – but this smoking fact is deliberately not mentioned). However, the statement 'a smoker runs two to three times the risk of having a heart attack as a non-smoker' is a far more complex assertion and – if understood in the same way as the previous statement, as a statement that one action (smoking) can directly and consistently cause a specific effect (a heart attack) – it is false, and therefore its inclusion as a 'fact' is deeply ethically controversial. While there are many studies which show that smoking does indeed increase some people's risk of suffering a heart attack, there is no simple causal relationship. There are very many variables to take into account (diet, exercise, weight, genetic make-up), and it is not certain that any individual smoker's smoking will cause her to suffer a heart attack. Data from 'the Framingham study'³³ for instance:

'... suggest that the effect of smoking seen in younger men disappears in older men and is largely absent in women'.³⁴

Thus there are at least two different sorts of 'smoking fact' in *The Health Guide*. The one commonplace and virtually certain, the other complex and only very generally true. Yet as they are presented both facts look (and no doubt are meant to look) exactly the same.

OPINIONS DRESSED AS FACTS

Some of the statements in *The Health Guide* are not facts in any sense, they are opinions (particular *interpretations* of the evidence). For instance, consider two non-factual statements about smoking (both presented as facts) contained in the booklet:

Giving up smoking is the most important step people can take to improve their health . . .
Smoking is anti-social.

Expand them just a little and it is possible to detect the way in which the authors of *The Health Guide* have merged together evidence and points of view to produce statements they mistakenly describe as factual:

Giving up smoking is the most important step people can take to improve their health (**this is opinion**) because smoking is – as far as current research is able to establish – the greatest cause of preventable morbidity in individuals (**fact – if this is true**). The more disease a person has the less healthy he is (**opinion – it depends what is meant by health**) and the more morbidity there is in society the less healthy that society is (**opinion again**).

Smoking can be unpleasant for others (**fact**) and there is evidence that it can cause disease in non-smokers through passive smoking (**fact – if this is true**). For these reasons smoking is anti-social (**opinion**).

EXCESSIVE ADVOCACY?

There is a great deal of evidence that health promoters have been remarkably successful in getting 'the anti-smoking message' across – so successful in fact that: '... the USA public now perceives the risks from smoking to be much higher than the actual risk'.³⁵

Possibly the truth looks like this:³⁶

	Perceived by smokers	Perceived by everyone	Actual
Lifetime risk of lung cancer to smoker	37%	43%	6–13%
Lifetime mortality risk to smoker	47%	54%	18–36%
Lifetime mortality risk to someone (smoker and others)			23–46%
Average years of life lost	7.0–18.8**	11.5	3.6–7.2

**Variations with age: older smokers, presumably less affected over the years by recent information campaigns, perceive their average loss to be less than do younger smokers who have been more affected by that information.³⁵

Although Viscusi's is only one study, and his results may be inaccurate, it is interesting to note that:

Extrapolating from other facts about the relationship between risk perception and actual choice to smoke, Viscusi shockingly estimates that if people had accurate rather than inflated risk perceptions, another 8% of the USA population would smoke!³⁵

Now, given that 'giving up smoking is the most important step people can take to improve their health' the fact that this 8% do not now smoke must, presumably, be regarded as a success by health promoters. But, assuming that Viscusi's data are true, this success rests upon the American public being collectively *deceived* (albeit perhaps unintentionally) about the actual physical risks they face or would face as smokers. Thanks to health promotion campaigners the USA public does not know the truth about smoking. Perhaps the end justifies the means in this case (a debatable point which, of course, cannot actually be publicly debated if the deception is to be kept up). However it is highly likely that such deception in other walks of life (even in *commercial* advertising³⁷) would be widely condemned as unethical.

Imagine if the aforementioned government health promoter were to continue with her anti-rugby campaign when there was already evidence that New Zealanders greatly over-estimated the risks. And imagine the reaction of most of today's Western bioethicists if they discovered that doctors had deliberately been grossly over-simplifying (as in the HEA guide) and even distorting information (as in Viscusi's data) in order to gain individuals' consent to surgery. Even if the doctors had a genuine altruistic concern for their patients, and had the future welfare of the human race at heart, it is hard to imagine (in today's ethical climate) that their actions could possibly be condoned.^{38,39} Even if it turned out that the patients benefited, even if they were cured as a direct result of the intervention, we hold *not being deceived* in such high regard (in individualistic cultures at least) that the doctors' behaviour would be widely considered to be unacceptable.

But it is apparently alright for health promoters to deceive. Either that or systematic deception by official health promotion continues to proceed largely unnoticed. Health promotion is seen as mainstream, conventional, traditional – and so non-problematic. But once it is recognised that convention is not *automatically* morally superior (and it is very easy to see this – just consider the European colonists' continuing treatment of indigenous peoples,⁴⁰ or Western society's constant discrimination against homosexuals⁴¹ – both of which are profoundly conventional *and* deeply questionable), and once it is seen that convention is *one* option amongst a host of others, then it is obvious that health promotion's generally uncontroversial appearance is just that – appearance.

Since matters of what to promote in the name of health, and how to do it, are quite clearly *not* finally decidable *purely* by appeal to the facts then continuing, in-depth discussion about values and social priorities is obviously required in a democratic society: and to make such sustained discussion about matters of ethics possible health promotion's theoretical side patently requires considerable development.

EXERCISE FOUR**REAL LIVES**

Think about the following residents of *Pakeha Street*:

Jane

Jane Smith is not happy, but she is getting by. She is 26, and works at home, caring for her two children (who are 2 and 3 years old) and the house. Jane has decided that she does not like her husband, John, very much – never mind love him. He is selfish, overbearing and, when they disagree, he must always get his way – or else he will lose his temper and sulk until he does.

Despite her feelings (and situation) Jane has decided to stay with John, at least until the children have left school. She hopes that she will be able to find some sort of employment when they are attending junior school. To cope with her life Jane smokes a few cigarettes a day, and has taken to drinking about half of a quarter bottle of vodka a day (John doesn't know she drinks).

Michael

Michael Jones (31) loves to be fit. He has been in training since his early twenties and has an excellent, sinewy physique. He particularly enjoys running, and regularly competes in long-distance events as an individual entrant. Michael is an administrator at the local government offices, but this is a means to an end only (he finds the work very tedious). He uses his wages to pay off a large loan he took out to build a fully equipped private gym at his house, to travel to running events, and to buy the latest gear and magazines.

Michael is single, has no close friends, and over the past few months has found that he has become increasingly tired and does not find it as easy to concentrate as he used to. Worse than this, from Michael's point of view, he has found that the muscles beneath his right calf are becoming stiff and sore, and that he is getting stabbing pains in his left knee as he begins each run.

Andrea

Andrea Barlow (42) used to be a secondary school teacher but lost her permanent post after a year-long virus infection, which she suffered in her mid-thirties. Since then Andrea has been a supply teacher, taking temporary work whenever she could. She has applied for dozens of full-time posts, but has had only one unsuccessful (and demoralising) interview.

Andrea's stints as a supply teacher have become shorter and shorter, and she suspects that certain people locally – who have influence in teaching circles – dislike her. She has had three temporary jobs in the past year and each time she has complained to the Head, after only a few weeks, that she is being picked on by other teachers. She claims always to get the most unruly classes and her notes go missing regularly.

Andrea lives with her elderly mother, Dorothy, who is becoming noticeably confused.

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Now explain:

- a. The health promotion priorities in each of these cases.
- b. Which methods you believe to be most effective and/or most moral to employ in order to achieve these priorities.
- c. If with others who have offered different answers to a and b, attempt to persuade them that your priorities and methods are *truly* health promoting (take careful note, in so doing, of the extent to which values, ethics and prejudice must play a part, and the extent to which other people's prejudices become very difficult to counteract unless you have a developed theory to help you).

If attempting this exercise independently imagine, in detail, how you would respond to a sceptic.